3-2-2017

Jobe v. Dirne Clinic/Heritage Health Appellant's Brief Dckt. 44604

IN THE SUPREME COURT OF THE STATE OF IDAHO

RICHARD JOBE, Claimant-Appellant, vs. DIRNE CLINIC/HERITAGE HEALTH Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants-Respondents,	)	Docket No. 44604 I.C. No. 2014-014091 APPELLANT'S OPENING BRIEF

APPEAL FROM THE INDUSTRIAL COMMISSION
OF THE STATE OF IDAHO

CHAIRMAN R.D. MAYNARD PRESIDING

Stephen Nemec, ISB No. 7591
James, Vernon & Weeks, P.A.
1626 Lincoln Way
Coeur d'Alene, ID 83814
Telephone: (208) 667-0683
Facsimile: (208) 664-1684

Attorney for Appellant

H. James Magnuson, ISB No. 2480
Attorney at Law
P.O. Box 2288
Coeur d' Alene, ID 83816-2288
Telephone: (208) 666-1596
Facsimile: (208) 666-1700

Attorney for Respondent

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I. STATEMENT OF THE CASE

A. Nature of the Case

This is an occupational disease claim pursuant to I.C. §72-437 and I.C. §72-439 originating from a methicillin-resistant Staphylococcus aureus ("MRSA") infection that was initially diagnosed in health care worker Richard Jobe, MD, ("Claimant") in June of 2013. R. p. 70. The infection presented in the Claimant's right hand before becoming systemic and spreading throughout his body, requiring numerous surgeries to manage the MRSA infection. *See* R. p. 1 and 82; Hull Depo Tr. p. 10; Riedo Depo. Tr. pp 39-40; CE 19, p. 1982; CE 21, p. 2005. While acknowledging that health care workers are approximately four to five times more likely to carry colonized MRSA than the general public, the Industrial Commission determined that the Claimant, "failed to prove his MRSA infection constitutes a compensable occupational disease caused by his employment with Employer." R. p. 79 and 89.

B. Course of the Proceedings

On May 29, 2014, Claimant filed a Complaint for medical and indemnity benefits relating to a MRSA infection that had spread throughout Claimant's body. R. p. 1. On June 19, 2014, the Employer/Surety filed an Answer denying responsibility for any medical and indemnity benefits. R. p. 4. On March 4, 2016, a hearing was held by Referee Harper in Coeur d' Alene to determine if the Employer/Surety was liable for the MRSA occupational disease claim. R. pp. 6-7. On September 23, 2016, Referee Harper issued his findings of fact, conclusions of law, and recommendation. R. pp. 67-88. On September 23, 2016, the Commission approved the proposed findings of fact, conclusions of law and recommendation of Referee Harper and entered an Order which determined that the, "Claimant failed to prove his MRSA infection constitutes a compensable occupational disease caused

by his employment with the Employer." R. p. 89. A notice of appeal was timely filed on November 3, 2016. R. p. 91.

C. Concise Statement of Facts

Claimant is a physician who obtained his medical degree from the University Of Missouri School of Medicine in 1961. (CE 4, p. 28). He went on to complete a residency in Internal Medicine along with a fellowship in Hematology and Medical Oncology at the University of Missouri in 1965. *Id.* From approximately 1965 until his last day at Heritage Health on June 19, 2013, Dr. Jobe worked primarily as an internist and hospitalist utilizing his fellowship training in hematology and oncology. (*Id.* at pgs. 28-30; *See* also DE 1, p. 203). It is believed that the Claimant was officially terminated from Heritage Health August 29, 2014. (CE 26, p. 2527)

On October 8, 2012, Dr. Jobe started his employment at Heritage Health and worked five days a week as an internist as well as going into work on Saturdays to get caught up on paperwork. (DE 1, p. 32; *See* also Hrg. Tr. pp. 20-21). Dr. Jobe's medical assistant during this period was Deborah Gutierrez (DE 1, p. 203). Ms. Gutierrez testified that health care workers at Heritage Health would frequently come into contact with MRSA colonized individuals:

Q: Okay. Have you ever had occasion to come into contact with patients that are colonized with MRSA—
A: Sure.
Q: --during the course and scope of your duties?
A: Absolutely. Every day. But – well, maybe not every day, but frequently. We frequently deal with people that have, you know, hep C, MRSA, and other things. We have to very careful.
. . .
Q: Going back to June of 2013, in your own opinion, how many times a month would you see someone that was colonized with MRSA?
A: Gosh, maybe four times – maybe one a week, I'd say at least. (*See* CE 25, p. 2514).

In addition to Mrs. Gutierrez's testimony on this issue, it is documented that the Claimant had direct contact with at least one MRSA colonized individual on March 25, 2013, in a redacted medical record

(CE 7, p. 58). Unfortunately, Defendants refused to produce any redacted medical records in discovery documenting the extent of MRSA colonized patients treated by the Claimant at Heritage Health in order to further investigate Mrs. Guiterrez's testimony (CE 26, p. 2525).

On June 17, 2013, Claimant presented to Dr. Mullen at Kootenai Hand and Reconstructive Surgery complaining of, "sudden onset of right thumb pain base pain that radiated into the wrist. He does not recall any specific trauma, but he said that several days ago he was descending some stairs and speculates he may have somehow traumatized the base of the thumb on the handrail." (CE 8, p. 58). Dr. Mullen assessed an acute exacerbation of arthritis with superimposed pseudogout and performed a steroid injection to reduce inflammation. *Id.* On June 19, 2013, when his symptoms had not improved, Dr. Mullen admitted the Claimant to Kootenai Health due to concerns over a septic wrist as a small amount of lymphangitic streaking was noted on the volar surface of the wrist and the Claimant, "does seem to be slightly confused." (CE 11, p. 612).

On June 20, 22, 24, 25, and the 28 of 2013, Dr. Mullen performed five separate surgeries on the Claimant's right hand in an attempt to control the MRSA infection. (CE 8, pp. 86-92). On June 20, 2013, Claimant was evaluated by infectious disease specialist Dr. Souvenir who also documented in a note that, "the only trauma that was elicited was a cat scratch approximately 3 weeks ago to the right hand web space between his 1st and 2nd metacarpals of the right hand." (CE 11, p. 654).[1] On July 1, 2013, Dr. Gertson, summarized Claimant's treatment by noting that, "Persistent positive blood cultures prompted further investigation and he was found to have a psoas abscess, which was drained. Tranesophageal echo revealed an aortic valvular vegetation. During his entire hospitalization, Dr. Jobe has been on IV vancomycin. At this point, there is concern about continuing to see positive

[1] It should be noted that Idalla Jobe testified at hearing that, "He didn't have a cat scratch. And I don't even know how that got put in there. We were very puzzled about how that happened. And we were just hypothesizing or brainstorming and it got put in there. I don't know why, but it did. And, of course, it went from a scratch to a bite. It's ridiculous." (Hrg. Tr. p. 26).

blood cultures, raising concern whether or not his PICC line is infected." (CE 11, p. 752 and 843). However, after several more days of treatment it appears Claimant was eventually discharged from Kootenai Health on July 10, 2013. (*Id.* at 838).

On July 24, 2013, Dr. Souvenir summarized the course of care to date in a progress note where he stated:

> The patient is a 77-year old man who is currently day 17 IV daptomycin, after 16 days of vancomycin. His blood cultures turned negative finally with transition to IV daptomycin and oral rifampin. He has MRSA disseminated disease, including aortic valve endocarditis, psoas abscesses, multiple right hand abscesses. He continues to have an elevated sedimentation rate. (CE 10, p. 464).

Dr. Souvenir anticipated another consult in two weeks following continued therapy, but when Claimant began to experience new pain in his spine, Dr. Souvenir ordered an MRI which revealed, "osteomyelistis at the T7-T8 levels with epidural and paravertebral phlegmon. There was moderate canal narrowing at the T7-T8 region, the T7-T8 disc was obliterated" and Claimant presented to the Emergency Room at Kootenai Health on August 2, 2013. (CE 10, p. 466; CE 11, p. 867).

A consult was requested with neurosurgeon Dr. Larson who recommended immediate surgery as the Claimant was, "showing signs of enhancement around the spinal cord which poses a potential problem of epidural abscess formation with spinal cord compromise. The infection needs to be treated surgically on the basis of it being refractory to IV antibiotics and because of the location and complications it may pose." (CE 11, p. 873). On August 4, 2013, Dr. Larson performed a transthoracic anterior vertebrectomy with decompression T7, T8, anterior fusion T6-T9, prosthetic cage implant T7 and T8, right anterior iliac crest bone marrow aspirate for morcellized autograft, anterior instrumentation of T6-T9. (CE 11 pp. 971-974; CE 17, p. 1905).

On August 7, 2013, due to consistently positive blood cultures for MRSA, Dr. Mullen and Dr. Bowen performed debridement of infected bone in the right upper extremity including the entirety

of the carpus with the exception of the pisiform with excision of the distal radial ulnar joint, excision of the distal ulna, and debridement of infected bone in the distal radius in the base of the index, middle, ring, and short finger metacarpals with placement of antibiotic beads. (CE 11, pp. 975-976). This was followed up by additional surgeries by Dr. Mullen on August 9, 12, 14, 16, of 2013 to drain the right wrist and place additional antibiotic beads. (CE 11, pp. 980-987).

Claimant was then eventually discharged from Kootenai Health and transferred to North Idaho Advanced Care Hospital ("NIACH") on August 20, 2013. Unfortunately, he had a stroke at NIACH on August 26, 2013, requiring readmission to Kootenai Health where he was treated with thrombolytic therapy and also for a gastrointestinal bleed. (CE 11 pp. 989-990). A cranial MRI showed evidence of a left cerebral infarct explaining Claimant's aphasia and he was discharged on August 29, 2013, and sent back to NIACH. On September 26, 2013, Claimant was discharged from NIACH and transferred to St. Luke's in Spokane, WA for further rehabilitation. (CE 12, p. 1118).

Claimant was admitted to St. Luke's on September 26, 2013 and eventually discharged on November 1, 2013. (CE 13, pp. 1570-1572). Unfortunately, on October 7, 2013, Claimant's recovery was further compromised when a transport van driver wheeled the Claimant out of the back of the van in a wheelchair and allowed him to fall approximately four feet onto the pavement causing additional injury to his spine and left shoulder. (See Hrg. Tr. p. 25; See also CE 13, p. 1619 and 1622). On October 8, 2013, x-rays at Inland Imaging revealed, "Mildly increased lucency at the bone prosthetic interface of the glenoid total shoulder component. This is suspicious for a degree of loosening, though this is age indeterminate." (CE 15, p. 1835). On October 17, 2013, a diagnostic ultrasound of the left shoulder confirmed:

1. Moderate to large sized joint effusion. Suspect moderate synovial hyperplasia. Hemarthrosis would be in the differential.
2. Full-thickness retracted infraspinatus tendon tear, as above.
3. Biceps tendon is not definitively identified and presumed ruptured/retracted

4. Suspect a full-thickness tear of the subscapularis tendon (CE 15, pp. 1838).

At discharge from St. Luke's, Claimant's injuries were summarized as a stroke with mild right hemiparesis; receptive and expressive aphasia: Improving. Still impulsive and has safety issues; left sided weakness in shoulder due to rotator cuff tear; s/p MRSA sepsis; T6/T7 osteomyelitis requiring surgical debridement and fusion; hemochromatosis; prior left hip THA and bilateral TSA's; prior bilateral ankle fusions; and prior cervical and lumbar fusions. (CE 13, p. 1571).

Claimant was then admitted to Life Care in Post Falls on November 1, 2013, where his rehabilitation continued until date of discharge on April 23, 2014. Shortly after admission, Claimant was again seen by Dr. Bowen at his clinic for his left shoulder pain on December 13, 2013. Dr. Bowen assessed a left shoulder rotator cuff tear around shoulder hemiarthroplasty but did not recommend surgical treatment at that time. (CE 18, p. 1927). On March 21, 2014, Claimant elected to proceed with surgical intervention on his left iliopsoas bursa with Dr. Bowen at Kootenai Health due to a MRSA infection. (CE 11, p. 1017). While this surgery was a success, Claimant continued to test positive for MRSA in his L THA and L TSA and Spine. (CE 18, p. 1938)

For the next year and a half, Claimant treated primarily with Dr. Souvenir utilizing a variety of antibiotics in an attempt to manage the MRSA infection. Dr. Souvenir noted on June 16, 2014, that given the severity of the infection and the presence of hardware, options of I&D versus complete explanation would need to be explored. (CE 11, p. 1055). On June 17, 2014, in response to a letter from Claimant's counsel dated 5/30/16, Dr. Souvenir stated, "I believe on a more likely than not basis (51% or greater) that Dr. Jobe's MRSA colonization is due to his exposure to MRSA in the course and scope of his duties as a physician." (CE 10, pp. 605-607). Over the course of the next year Claimant continued to perform a regimen of swimming several times a week and also began

speech therapy in February of 2015 thru June of 2015 at the McGrane Center at Kootenai Health. (CE 11, pp. 1073-1116).

On June 24, 2015, Dr. Riedo performed an exam at the request of the Defendants to assess how the Claimant acquired his MRSA. Dr. Riedo notably stated that, "While there are some studies that show that some healthcare providers are at an increased risk for MRSA, this should be placed in the context that positive studies will be published and negative studies will not be published. A finding that healthcare workers do not show an increased risk of MRSA will not appear as a significant finding." (DE 4, p. 239). Accordingly, Dr. Riedo concluded his report by stating that, "I do not believe it is possible, on a more probable than not basis, to attribute Dr. Jobe's acquisition of MRSA colonization or MRSA infection to his employment at Dirne Medical Clinic." *Id.* However, Dr. Riedo did testify that average colonization with MRSA is "**around nine months.**" (Riedo Depo. p. 30, ln. 4-12). Claimant was employed with Employer for 8.35 months. (DE 1, p. 32 and 203)

On September 16, 2015, Claimant presented to Dr. McNulty for a physical examination of body parts affected by his MRSA infection for an impairment rating. (CE 19, pp. 1981-1982). Dr. McNulty rated Claimant with a 75% lower extremity impairment for his left hip, 46% upper extremity impairment for his left shoulder, 35% whole person impairment for his aphasia, 22% whole person impairment for his thoracic spine, and a 14% upper extremity impairment for his right hand with an additional 2% upper extremity impairment for loss of forearm rotation. *Id.* At his deposition, Dr. McNulty further apportioned his findings to the MRSA infection by directly attributing a 50% lower extremity impairment to the left hip and a 22% upper extremity impairment to the left shoulder. (McNulty Depo. pp. 9-10). Dr. McNulty's impairment ratings for the aphasia, thoracic spine, and right hand conditions were entirely apportioned to the MRSA

infection. (*Id.* at pgs. 10-12). In total, Dr. McNulty directly attributed a 67% whole person impairment to the MRSA infection and opined that the Claimant was totally and permanently disabled. (*Id.* at p. 14, ln. 24; CE 19, p. 1982). On September 29, 2015, vocational expert Fred Cutler reviewed the IME reports of Dr. Riedo and Dr. McNulty and stated:

> It is without doubt based on my review of these two medical evaluations that Dr. Jobe is totally and permanently disabled. He has no access to the labor market and certainly cannot be expected to perform any sustained work activity even at the most unskilled level. I would agree with Dr. McNulty's statement that the aphasia alone is sufficient to remove Dr. Jobe from any type of work activity. However, clearly there are multiple other issues that are effecting his ability to function which only compound his incapacity. (CE 20, p. 1991).

In early February of 2016, infectious disease epidemiologist Dr. Harry Hull issued his report after reviewing all the relevant medical records as well as the latest medical journals on MRSA colonization and infection rates and concluded that:

> Because Dr. Jobe is a physician who had examined and treated MRSA-infected patients, it is more likely than not that the source of the MRSA bacteria causing Dr. Jobe's MRSA infection is one of the patients he examined in the months preceding the onset of his MRSA infection. (CE 21., pgs. 2006-2007).

Specifically, Dr. Hull noted that 4-5% of health care workers, including physicians are carriers of MRSA as compared to approximately 1% of healthy members of the public. (*Id.* at 2004-2005). However, the majority of MRSA carriers in the community have healthcare associated risk factors. The rate of MRSA carriers in the general population who have none of the usual risk factors for MRSA is only .24%. (*Id.*; See also CE 22, p. 2276; Hull Depo. pgs. 15-17). Accordingly, healthcare workers are carriers of MRSA at rates 15-20 times higher than persons in the general population with no risk factors. *Id.*

In late February of 2016, Dr. Bowen performed an explantation of the left hip with placement of antibiotic spacer and incised and drained the abscess. (CE 27, p. 2535). Unfortunately, immediately following the surgery Claimant suffered another stroke which, "left him with a markedly worse

aphasia as well as right-sided weakness, primarily in the arm and face." (*Id.* at 2539). Following this medical record, the Claimant's medical record ends, but he has continued to receive medical treatment from various facilities previously discussed above and will likely continue to treat with Dr. Souvenir and Dr. Bowen. Specifically, Dr. Souvenir stated at his post-hearing deposition on March 25, 2016 that, "I think he has a chronically infected hip. Even though the artificial hip has been taken out, I still think that the surrounding bone is chronically infected and I plan to keep him on lifelong therapy." (Souvenir Depo, p. 18).

On September 23, 2016, the Commission acknowledged that health care workers like the Claimant are approximately four to five times more likely to carry colonized MRSA. R. p. 79. The Commission also concluded that the MRSA infection originated, "at or near Claimant's right hand, wrist, or arm." R. p. 82. The Commission further concluded that, "the evidence supports a scratch on his right hand from his cat within the weeks preceding the MRSA infection." *Id.* The Commission then conducted a legal analysis to determine if the Claimant had proven he was colonized with MRSA while at Dirne Clinic/Heritage Health. The Commission then adopted the opinion of Dr. Riedo over the opinions of Dr. Souvenir and Dr. Hull and determined that the Claimant, "failed to prove his MRSA infection constitutes a compensable occupational disease caused by his employment with Employer." R. p. 86-87.

II. ISSUES ON APPEAL

1. Did the Commission err as a matter of law in requiring Claimant to prove both MRSA colonization and MRSA infection while working for Employer?

III. STANDARD OF REVIEW

When this Court reviews a decision from the Industrial Commission, it exercises free review over questions of law but reviews questions of fact only to determine whether substantial and competent evidence supports the Commission's findings. *Vawter v. United Parcel Serv., Inc.,* 155 Idaho 903, 906-07, 318 P.3d 893, 896-97 (2014). Substantial and competent evidence is "relevant evidence which a reasonable mind might accept to support a conclusion." *Boise Orthopedic Clinic v. Idaho State Ins. Fund,* 128 Idaho 161, 164, 911 P.2d 754, 757 (1996). The Commission's conclusions on the credibility and weight of evidence will not be disturbed unless the conclusions are clearly erroneous. *Zapata v. J.R. Simplot Co.*, 132 Idaho 513, 515, 975 P.2d 1178, 1180 (1999).

IV. ARGUMENT

A. Introduction

This case involves an occupational disease claim for a MRSA infection. In order to prevail on this claim, the Industrial Commission determined that the Claimant needed to prove MRSA colonization and infection while employed at Dirne Clinic/Heritage Health from October 2012 through June 2013. R. p. 86. However, this Court has previously held that as an occupational disease develops over time, it is possible for the disease to be "incurred" by a claimant under a series of different employers before it becomes manifest. *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 456, 111 P.3d 135, 141 (2005). In such a situation, while the occupational disease may be causally related to more than one employment, only the employer in whose employment the employee was last injuriously exposed is liable for the claim. I.C. §72-439.

In this case, there is no evidence of manifestation prior to June of 2013 at the earliest. R. p. 85. More importantly, because "incurred" means " 'arising out of and in the course of'

employment," it is as much a reference to cause as to a particular point in time. *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 456, 111 P.3d 135, 141 (2005). In such a claim, Claimant needs to show on a more likely than not basis that his MRSA infection was incurred due to an injurious exposure due to his work treating MRSA colonized individuals for the Employer. The Commission's additional requirement that the Claimant prove both MRSA colonization and MRSA infection during his employment with Employer was an error of law.

1. **The Commission erred as a matter of law in requiring Claimant to prove MRSA colonization and MRSA infection while working for Employer**

The relevant statutes governing compensability for occupational disease claims are I.C. §72-437 and I.C. §72-439 which state as follows:

> **72-437. OCCUPATIONAL DISEASES — RIGHT TO COMPENSATION.** When an employee of an employer suffers an occupational disease and is thereby disabled from performing his work in the last occupation in which he was injuriously exposed to the hazards of such disease, or dies as a result of such disease, and the disease was due to the nature of an occupation or process in which he was employed within the period previous to his disablement as hereinafter limited, the employee, or, in case of his death, his dependents shall be entitled to compensation.
>
> **72-439. ACTUALLY INCURRED/NONACUTE OCCUPATIONAL DISEASE.** (1) An employer shall not be liable for any compensation for an occupational disease unless such disease is actually incurred in the employer's employment.
> (2) An employer shall not be liable for any compensation for a nonacute occupational disease unless the employee was exposed to the hazard of such disease for a period of sixty (60) days for the same employer.
> (3) Where compensation is payable for an occupational disease, the employer, or the surety on the risk for the employer, in whose employment the employee was last injuriously exposed to the hazard of such disease, shall be liable therefor.

As an occupational disease develops over time, it is possible for the disease to be "incurred" by a claimant under a series of different employers before it becomes manifest. *Sundquist v. Precision Steel & Gypsum, Inc.*, 141 Idaho 450, 456, 111 P.3d 135, 141 (2005). "Manifestation" means the time when an employee knows that he has an occupational disease, or whenever a qualified

physician shall inform the injured worker that he has an occupational disease. I.C. §72-102(19). "Occupational disease" means a disease due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process, or employment, but shall not include psychological injuries, disorders or conditions unless the conditions set forth in section I.C. §72-451, Idaho Code, are met. I.C. §72-102(22)(a). "Incurred," when referring to an occupational disease, shall be deemed the equivalent of the term "arising out of and in the course of" employment. I.C. §72-102 (22) (b). It is sufficient to say that an injury is received "in the course of" the employment when it comes while the workman is doing the duty which he is employed to perform. It arises "out of" the employment when there is apparent to the rational mind upon consideration of all the circumstances, a causal connection between the conditions under which the work is required to be performed and the resulting injury."

In this case, the MRSA infection did not manifest until June 19, 2013 at the absolute earliest (manifestation date is more likely 6/17/14) when Claimant had to quit seeing patients at the Dirne Clinic at noon to present at Dr. Mullen's office for evaluation and admittance to Kootenai Health. *See* DE 1, p. 203; CE 11, pp. 630-631, CE 10 Ex. J, pp. 605-607. Claimant never returned to work at Dirne Clinic/Heritage Health after his admission to the hospital on June 19, 2013. *Id.* While the Commission determined that the Claimant's MRSA infection presented several weeks after a cat scratch to the right hand and entered the Claimant's body thru the right hand, the Commission never conducted a proper legal analysis to determine if Claimant was injuriously exposed to MRSA at Dirne Clinic/Heritage Health as required by I.C. §72-437 and I.C. §72-439. R. p. 82. Instead, the Commission spent several pages of analysis discussing colonization issues and the requirement that Claimant affirmatively prove that MRSA colonization occurred at Dirne Clinic/Heritage Health to

the exclusion of his former employment instead of whether Claimant's MRSA infection was due to injurious exposure to MRSA colonized individuals at Dirne Clinic/Heritage Health. R. p. 84-86.

Because Debra Gutierrez's testimony that the Claimant treated MRSA colonized patients at least once a week was unrebutted, the Commission must accept as true the proposition that the Claimant was exposed to MRSA colonized patients at work for weeks following the cat scratch that was referenced prior to Claimant's admission to Kootenai Health. *See Pierstorff v. Gray's Auto Shop*, 58 Idaho 438, 447-48, 74 P.2d 171, 175 (1937); *See* also Souvenir Depo, p. 9 ln. 11-18; CE 25, p. 2514. This evidence satisfies the requirement of I.C. §72-437 and §72-439 for injurious exposure. Indeed, based on the evidence of record, Claimant's **only known exposures** to MRSA all occurred at Dirne Clinic/Heritage Health in the 254 days he worked there prior to hospitalization. CE 25, p. 2514 and DE 1, p. 203. To conclude that the Claimant acquired his MRSA infection from a variety of unknown sources as Dr. Riedo does in the face of Debra Gutierrez's testimony is to engage in speculation that is not supported by the evidence of record.

In addition to the fact that the only known MRSA exposures in Claimant's history occurred at Dirne Clinic/Heritage Health, Dr. Riedo testified that the average time that an individual is MRSA colonized is **approximately nine months**. Riedo Depo. Tr. p. 30, ln. 4-12. As the Claimant worked at the Employer's facility for 254 days or 8.35 months, on a more likely than not basis this would rule out the surgeries referenced by the Commission in the years prior to the MRSA infection as potential sources of colonization and eventual infection due to a break in the skin. (DE 1, p. 32 and 203). Dr. Riedo's statement that the average duration of MRSA colonization of nine months fits perfectly with Dr. Hull's conclusion that, "Because Dr. Jobe is a physician who had examined and treated MRSA-infected patients, it is more likely than not that the source of the MRSA bacteria causing

Dr. Jobe's MRSA infection is one of the patients he examined in the months preceding the onset of his MRSA infection." CE 21, pp. 2006-2007.

As to the presentation of the MRSA infection in the Claimant's hand, Dr. Riedo commented that, "It should be noted that the most common mechanism of transmission is poor hand hygiene which may result in transient cutaneous colonization to allow transmission and not necessarily because health care workers are chronically colonized." (DE 7, p. 254). Dr. Hull also stated, "It is also significant that the site of Dr. Jobe's initial MRSA infection was his hand as physicians' hands are frequently contaminated with MRSA following physical examination of MRSA-infected patients." CE 21, p. 2006. When all the evidence in this case is weighed and analyzed on a more likely than not basis, it is clear that the Claimant was injuriously exposed to MRSA at Dirne Clinic/Heritage Health, resulting in a compensable occupational disease claim.

V. CONCLUSION

It is the policy of worker's compensation statutes to encourage "sure and certain relief for injured workers." I.C. §72-201. The provisions of the Workers Compensation law are to be liberally construed in favor of the employee. *Sprague v. Caldwell Transportation, Inc.*, 116 Idaho 720, 779 P.2d 395 (1989). The humane purposes which it serves leave no room for narrow technical construction. *Ogden v. Thompson,* 128 Idaho 87, 910 P.2d 759 (1996).

Based on the argument presented herein, this case should be remanded to the Industrial Commission with instructions to reconsider the evidence in accordance with I.C. §72-437 and I.C. §72-439. The Commission should then determine on a more likely than not basis whether the Claimant was injuriously exposed to MRSA while treating patients at Dirne Clinic/Heritage Health resulting in his MRSA infection, instead of requiring the Claimant to prove both MRSA

colonization and MRSA infection during the period he was employed at Dirne Clinic/Heritage Health.

RESPECTFULLY SUBMITTTED this 27th day of February, 2017.

Stephen Nemec, ISB No. 7591
Attorney for Claimant-Appellant

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 27th day of February, 2017, two true and correct copies of the foregoing document were served upon the following individuals by the method indicated below:

H. James Magnuson 1250 Northwood Center Court P.O. Box 2288 Coeur d'Alene, Idaho 83816 ***Attorney for Respondent***			
X	Mailed		Mailed
	By Hand		By Hand
	Overnight Mail		Overnight Mail
	Fax: 666-1700		Fax